California Department of PublicHealth

Center for Health Care Quality
Licensing and Certification Program
Centralized Applications Branch

Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) Report of Change Application Checklist for Change of Bed

The following is a list of forms and supporting documents required for a complete application packet. Failure to include each of the forms or documents will delay processing.

Check all that apply: ☐ **Add/Reactivate** ☐ **Remove** ☐ **Suspend**

CHECKLIST AND INSTRUCTIONS - *Please submit your documents in this order.*

REQUIED DOCUMENTS TO ADD/REACTIVATE/ REMOVE A BED(S)

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Cover Letter	**COVER LETTER** Letter on company letterhead with the following information: • License number • Facility name and address • Facility ID number (if known) • Brief description of request • Contact information (name, title, phone number, and e-mail address) • Emergency Contact Information (name, email, alternate email, phone, fax, and phone number that will receive text messages). The Department will use this information to contact the provider in the event of an emergency using the California Health Alert Network (CAHAN). All information provided must allow CAHAN to contact the provider on a 24/7/365 basis for distribution of health alerts. For additional information: CAHAN (https://www.calhospitalprepare.org/cahan) • Signature

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 200	**LICENSURE & CERTIFICATION APPLICATION** **SNF and ICF:** Health and Safety Code (HSC) section 1271.1 **SNF:** Title 22 of the California Code of Regulations (CCR) sections 7220 and 72211 **ICF:** 22 CCR sections 73203 and 73214 **Tips:** • Page 2, Section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent company. This parent company will have its own Employer Identification Number (EIN). • Page 3, Section C, item 7 — When listing the names of individuals with direct or indirect ownership of the facility in section C, provide the EIN (do not enter a Social Security number in this field).
	Supporting Documents	**A.11 - OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT (OSHPD) AND/ OR CERTIFICATE OF OCCUPANCY CONSTRUCTION** **SNF and ICF:** HSC section 1276 & 1275 **SNF:** 22 CCR section 72205, 72601, 72607, and 72603 **ICF:** 22 CCR section 73213,73601, and 73605 **If this <u>is</u> a newly constructed and/or remodeled building, <u>or</u> if this is <u>not</u> a previously licensed facility (i.e., existing building with no construction or remodeling required)** applicant needs to contact the Office of Statewide Health Planning & Development (OSHPD) at the following website for Title 24 clearance: www.oshpd.ca.gov
	Supporting Documents	**FLOOR PLAN** Submit a floor plan that describes the requested change of beds including a schematic of the room(s)

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	STD 850	**FIRE SAFETY INSPECTION REQUEST** **SNF:** 22 CCR section 72205 and 72607 **ICF:** 22 CCR sections 73213 The STD 850 form must be submitted or a similar form from the fire authority that contains equivalent information as the STD 850 form. The OSHPD Fire Life & Safety (FLS) Inspection approval does not replace this form.
	CDPH 609	**BED OR SERVICE REQUEST** Complete the columns marked “Existing Beds” and “Existing Services” and the columns marked “Requested Beds” and “Requested Services”